DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 04 — 04

2. STATE: West Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.130

7. FEDERAL BUDGET IMPACT:
a. FFY 2005 $ 3,688,941
b. FFY 2006 $ 3,688,941

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 2 to
ATTACHMENT for 3.1-A and 3.1-B
Pages 4c and 4d
ATTACHMENT 4.19 B, PAGE 10.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Modification of diabetic disease state management to provide for enrollment of certified diabetic educators.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Nancy V. Atkins

13. TYPED NAME:
Nancy V. Atkins, MSN, RNC, NP

14. TITLE:
Commissioner

15. DATE SUBMITTED:

16. RETURN TO:
Nancy V. Atkins, MSN, RNC, NP
Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
Sept. 28, 2004

18. DATE APPROVED:
DEC 03 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
Oct. 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Roseanne Egan

21. TYPED NAME:
Roseanne Egan

22. TITLE:
Acting Deputy Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

13. c Preventive Services

Disease State Management

Disease State Management (DSM) will provide certain health care services by a licensed practitioner in a coordinated approach seeking to prevent serious complications to Medicaid eligible individuals who are determined to have Type 1, Type 2 or gestational diabetes mellitus. Licensed practitioners, operating within the scope of their licenses, will provide diabetics with an interdisciplinary support team formed around the recipients' primary care provider. The team may be based on community resources; hospitals, pharmacies, rural health clinics (RHC), federally qualified health centers (FQHC), independent certified diabetic educators (CDE), along with other resources that are within each community. The primary care provider will agree to manage the recipient and will be expected to either provide or refer the patients for diabetic disease state management services.

People with diabetes in this group will benefit from a patient-centered health care approach that is responsive to the unique needs and conditions of people living with diabetes to produce the best treatment outcomes in a cost-effective manner by demonstrating quantifiable and measurable results. A patient evaluation instrument will be used for initial and ongoing screening for patients, including a flow sheet evaluation form and a diabetic educational assessment form. These forms, which are completed by the patient's primary care provider, will define the health care and health related support needs of the patient.

Components of Disease State Management

The health care related needs of diabetics recipients will be determined through comprehensive diabetes assessments.

Components will include:

- Diabetic assessment and education which will include a comprehensive assessment of the diabetic's status and health care needs, risk assessment, hygiene, and diet, etc.
- Drug Therapy will include evaluation of the diabetic's medication requirements, oral or injectable, self monitoring of blood glucose, recognition of emergency conditions, etc.
- Diet Management/Education will include education on diet restriction, eating patterns, diet and medication interaction, etc.
- Referral to other providers to meet identified health care needs, such as skin and/or wound care, eye or renal care, etc.

Licensed practitioners who are also CDEs and not subject to independent enrollment will be enrolled solely to provide diabetic disease state management services as herein provided. Providers who are enrolled in Medicaid must be certified as CDEs prior to billing. Providers will be certified through a process in conjunction with the Bureau for Medical Services. Providers must have a provider agreement with the Medicaid agency, must be enrolled as participating providers in Medicaid, and meet the criteria below.

Demonstrate a capacity to provide all core elements of disease state management services including:

- Comprehensive client assessment and service plan development.
- Assist the client to access needed services, i.e., assuring that services are appropriate to the clients' needs and that they are not duplicative or overlapping.
- Monitor and periodically reassess the client's status and needs.
- Demonstrate an administrative capacity to assure quality of services in accordance with state and federal requirements.
- Demonstrate ability to assure referral processes consistent with 1902 (a) (23), freedom of choice for providers.
- Demonstrate financial management capacity and system that provides documentation of services and cost.
- Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.
- Provide for certified diabetic educator services.

Certified Diabetic Educators (CDE) must be licensed practitioners and credentialed as a Certified Diabetes Educator by the National Certification Board for Diabetes Educators. This certification shows the applicant holds a current unrestricted state license as a registered nurse, an advanced nurse practitioner, pharmacist, physician, physician assistant, podiatrist, physical therapist, occupational therapist, clinical psychologist, social worker, or is registered as a dietician by the Commission on Dietetic Registration.

Disease State Management services are reimbursed on a fee-for service basis with certain limitations:

Description	Services Limits
Extended Provider's Office Visit	2 visits/year
Enrolled providers may also bill for the following:	
Outpatient self-management training visit -individual	8.5 hours/year
Outpatient self-management training visit - group session	8.5 hours/year
Follow-up visits/reassessment with CDE	2 visits/year

The outpatient self-management training sessions can be a combination of individual and group sessions, not exceeding 8.5 hours / year.

Number of total hours involving CDE education cannot exceed 10 hours / year per recipient.

4.19 Payment for Medical and Remedial Care and Services

6. Assurances: Payment for multiple source drugs will not exceed, in the aggregate, payment levels determined by applying for each drug entity a reasonable dispensing fee plus an amount established by HCFA that is equal to 150% of the published price for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules or, in the case of liquids, the commonly listed size, as required in 42 CFR 447.332 (a) & (b).

7. Manufacturer Restriction: Reimbursement for prescribed drugs will be limited to those drugs supplied from manufacturers that have signed a national agreement in accordance with Section 1927 of the Social Security Act (The Act), (as amended by Section 4401 of P.L. 101-508).

12. b. Dentures

Payment for dentures is included in item 10.

3. Prosthetic Devices

Payment is based on the upper limit established for the service by Medicare.

4. Eyeglasses

Payment will not exceed an upper limit established considering cost information from national sources; i.e., Optometry Today and Review of Optometry; a survey of practitioners in the State; and the upper limits established by Medicare adjusted to reflect complexity of material.

An upper limit is established for each lens code. The upper limit for frame is wholesale cost up to $40.00 multiplied by a factor 2.5. Payment for low vision aids may not exceed invoice cost plus 30 percent.

Reimbursement may not exceed the provider's customary charge for the service to the general public.

13. c. Preventive Services

Disease State Management

1. The state developed fee schedule rates are the same for both public and private providers of these 1905(a) services. The fee schedule and any annual/period adjustments to the fee schedule are published.

13. d. Rehabilitative Services

Behavioral Health Services

1. Reimbursement to those agencies licensed as behavioral